



# BLOOD SCREENING PROGRAM

Sponsored by: The Winter Garden Rotary Club

Lab Services provided as a community benefit by **Health Central Hospital**

**Wednesday, February 18, 2015**

Hours: 7:00 a.m. - 10:00 a.m.

Performed in the Gleason Room at Health Central

This early warning health test will be provided at a low cost to our community.

(Limited tests available, please pre-register)

**\$50 .00 PRE-REGISTERED • \$60.00 WALK-INS**

*Fees include entire process, including:*

- Collection of blood sample
- Analysis
- Confidential reporting directly to you

**FASTING:**

**Nothing to eat or drink (except water) for the previous eight (8) hours required.**

**PRE-REGISTRATION:**

Form must be received by Friday, February 13th. Complete the attached form and return with your check in the amount of \$50.00\* payable to:

**Winter Garden Rotary Club**

c/o Health Central Hospital

Attn: T. Duncan

10000 West Colonial Drive

Ocoee, FL 34761

**Questions? Call 407-296-1770**

**This screening helps identify current or potential health problems.**

*Tests allow the detection of many medical problems including:*

**ANEMIA**

- Red Blood Cell Count
- White Blood Cell Count
- Hemoglobin
- Hematocrit
- Platelet Count
- Red Blood Indices (MCV, MCH, MCHC)

**LIVER DISEASE**

- Albumin
- Total Bilirubin
- Total Protein
- SGOT
- SGPT
- Alkaline Phosphatase

**DIABETES**

- Glucose

**CORONARY/HEART DISEASE**

- Cholesterol
- Triglycerides
- HDL
- LDL

**KIDNEY DISEASE**

- Bun
- Creatinine
- GFR

**OTHER TESTS**

- Calcium Chloride
- Potassium
- Sodium
- Prostate Screening (males only)
- PSA
- Anion Gap

**MAIL THIS Registration Form**

Must be received by Friday, February 13th

Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_

State: \_\_\_\_\_ Zip: \_\_\_\_\_

Telephone: ( \_\_\_\_\_ ) \_\_\_\_\_

Email address: \_\_\_\_\_

Birthdate: \_\_\_\_\_ Male: \_\_\_ Female: \_\_\_

SS# (optional) \_\_\_\_\_

Family Physician: \_\_\_\_\_

**KEEP THIS form and present to:**

**Gleason Room at Health Central**

Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_

State: \_\_\_\_\_ Zip: \_\_\_\_\_

Birthdate: \_\_\_\_\_ Male: \_\_\_ Female: \_\_\_

Hospital requires your SS#: \_\_\_\_\_

A gift from: \_\_\_\_\_

*This is a laboratory screening test. It may or may not alert you and your doctor to a serious medical problem. The results of this test are not intended to substitute for your doctor's diagnosis and treatment. REMEMBER TO FAST*